STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from Ingham County Circuit Court, Lower Court No. 98-88770-CZ, Honorable Michael G. Harrison

BLAKEWOODS SURGERY CENTER, L.L.C. JACKSON MEDICAL SERVICES, INC., PAUL ERNEST, M.D., KEVIN LAVERY, M.D., ANTHONY SENSOLI, M.D., SIGMUND ANCEREWICZ, M.D., KHAWAJA IKRAM, D.O., SHARON ROONEY-GANDY, D.D., ARTHUR WIERENGA, M.D., MARTIN PATRIAS, M.D., MICHAEL CHAMES, M.D., GHULUM DASTGIR, M.D., AND KABINDRA MISHRA, M.D.,

Plaintiffs-Appellants,

S.C. No. 118935
C.O.A. No. 221494
Lower Ct. No. 98-88770-CZ

v.

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, in his official capacity.

Defendant-Appellee.

_____/

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ORAL ARGUMENT REQUESTED

_____/

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PLAINTIFFS-APPELLANTS' REPLY BRIEF ON APPEAL

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For their Reply to Appellee's Appeal Brief, Plaintiffs-Appellants submit the following.

Part 5 of 1980 PA 350 permits BCBSM to contract with providers to enable members to obtain care pursuant to their BCBSM health care benefits. BCBSM must develop reimbursement arrangements (*via* provider class plans) to enable the health care corporation to reimburse various types of providers such as neurosurgeons, orthopedic surgeons, general practitioners, hospitals, etc. who may lawfully render such services. Provider "classes" are defined by state licensure unless no license is required. *MCL 550.1105 (3), (4) & 550.1502 (8).* *Participation* with individual providers who belong to the "classes" of providers that BCBSM reimburses permits members to receive services that are fully covered (paid for) through BCBSM coverage (the patient is not billed for the difference between BCBSM's fee schedule amount and the provider's charge). If a BCBSM member obtains care from a non-participating provider who belongs to a "class" recognized by BCBSM, the law provides that BCBSM must reimburse the patient, directly. *See MCL 550.1401(7) & 1403 (1).* For example, BCBSM has established a reimbursement arrangement (provider class plan) for medical doctors, but when BCBSM members receive care from doctors who refuse to contract (participate) with BCBSM, BCBSM must pay the patient its fee for such services. The patient then pays the provider. The only instance in which BCBSM is permitted to restrict its providers to a limited "panel" is under the statutory provisions for "managed care". *See MCL 550. 1502(6) & 550.1502a.* The instant matter does not involve managed care. Appellee's Brief (*pp 11 & 13*) is

misleading. BCBSM can select the benefits it covers; it cannot dictate which providers may render care.

Pursuant to BCBSM's participation agreement, Blakewoods can be reimbursed only a fixed fee determined by BCBSM. Appellee argues that added physician-owned ambulatory surgical facilities increase the cost of care due to the cost of building and establishing such facilities (*p13,14 Appellee's Brief*) and that costs are increased, per surgery, if the volume of surgeries falls (*p 18, Appellee's Brief*). This is not true. Blakewoods is financed solely by its owners, pays taxes (unlike hospitals) and receives a fixed fee per surgery from BCBSM. Unlike hospitals (that Appellee references), physician-owned ambulatory surgery facilities are not reimbursed based on their costs and unlike hospitals, if their costs increase they cannot pass those increases on to BCBSM. If Blakewoods fails, only its owners sustain the loss. No costs are passed on to the health care finance system or the consumer. ASF's add access, quality and **price competition** that BCBSM is attempting to eliminate in deference to its long-maintained symbiotic relationships with the hospital providers. *See BCBSM v Milliken, 1 Mich 422; 1 NW2d 367 (1985), p27-28; 16, and App pp 33a-106a, 79 Mich Law Review 203 (1980),Regulation Through the Looking Glass, pp 53a, 55a-56a, 58a- 61a, 69a-72a, 75a,77a, 80a-82a, 90a-92a, 104a-106a, relied upon by the Court for background,* wherein the Court discusses the legislative intent of the new *Act* to eliminate such favoritism that had escalated costs.

Hospitals can maintain the BCBSM surgical volume standard in their ASFs by simply shifting surgeries from their outpatient operating rooms to their ASF's.

See p 34 of Appellee's Brief alluding to hospitals' ability to "jury-rig" the numbers by transferring surgical cases. Blakewoods cannot do this. The so-called BCBSM EON standards are therefore, discriminatory and force patients to receive care in the more costly setting, hospital.

Hospitals are the most costly setting in which to receive medical care. As Appellee has alluded to on *p 18* of his Brief, outpatient hospital units are reimbursed by BCBSM on a "cost" basis. Simply put, this means that the more it costs to operate the hospital, the greater the amount of BCBSM reimbursement, creating a perverse incentive to 'show' increased costs. In addition to the ASF facility fee for each surgery performed, an additional amount is paid by BCBSM based on each hospital's "cost-to-charge" ratio, an industry index for hospital costs. Hospitals have no incentive to restrict costs or to operate in an efficient manner; in fact, the opposite is true.

Appellee argues that licensure, alone, cannot be the only criteria for participation status. *(See p 18, Appellee's Brief)* This is true. Reimbursement criteria includes compliance with record-keeping and audit procedures, correct and timely use of uniform procedure and diagnosis coding on prescribed claim formats, compliance with utilization/review and reporting requirements, refraining from fraudulent practices, disclosure of ownership and organizational structure, *etc.*--criteria that may be required for participation. Appellee also makes much of the provider class plan review process. This ignores the fact that Appellants are asking for and have always sought an interpretation of the statute that governs BCBSM to determine whether or not the Appellee may permit BCBSM to make

medical provider "need" determinations that it can use to refuse participation status and recognition of Blakewoods' license. Whether or not a provider class plan review mechanism (that provides only for a narrow evaluation of a reimbursement arrangement) exists is irrelevant. As long ago as *Marbury v Madison, 1 Cranch 37; 2 L Ed 60,* it has been held that under the "separation of powers" doctrine, it is the province of the Court to say what the law is. Here, the question encompasses more than can be addressed under the *Part 5* provider class plan review process. *See MCL 550.1504 and 550.1509(1).* The question is whether either BCBSM or the Commissioner may assume the authority to interfere with any aspect of medical provider licensure without a specific legislative grant of authority. The question is whether, given the specific language of *MCL 1502(8)* that prescribes the standard for licensure and "need", BCBSM can establish its own EON process and attempt to enforce that process against medical providers, whose "need" and other licensure requirements are governed pursuant to the *Public Health Code.* The provider class plan review process does not eliminate the Court's jurisdiction to interpret the law. The Appellee seems to argue that as long as an *ultra vires* or unlawful activity is incorporated into a provider class plan, it is somehow insulated from review *ad infinitum.* Several arguments that the Commissioner makes regarding the provider class plan are misleading. First, the statute provides no means for providers to initiate a provider class plan review and the Commissioner is **never** obligated to conduct a provider class plan review of any given provider class plan. *See MCL 550.1509(7).* So, Appellants were not obligated to attempt to

initiate such a review. Even when Appellants sued the Commissioner regarding the instant dispute, he did not offer to conduct a provider class plan review until he was faced with the Ingham County Circuit Court's consideration of a Motion for Summary Disposition brought by Blakewoods. *See Tr. Ct. Hearing Trans. 1/13/99, App. pp 352a, In.23- p353a, In16, & p 355a, In 3-1.* Second, the provider class plan review does not provide for consideration of constitutional issues, or the interpretation of statutes. It is limited to only a narrow consideration of whether the reimbursement arrangement met or reasonably failed to meet three statutorily defined reimbursement goals: cost, access and quality. *See MCL 550.1504 & 550.1509(1).* The Commissioner found that the Plan had to be rewritten, but continued to permit BCBSM to use its EON, even though *Sec. 502 (8)* prescribed the "need" standard that was to be used and even though the *Act* contains no specific delegation of authority for either the Commissioner or BCBSM to determine provider "need" or to make any determination about who or what will be recognized as a medical provider. This process has no mechanism for Appellants to obtain a remedy. Additionally, what the Commissioner failed to disclose is that under the provider class plan review system, each time BCBSM files a new Plan or modification of a Plan, the Commissioner considers all previous plans and the orders or disputes that are generated by previous plans "moot".[1] Here, BCBSM has filed two modified ambulatory surgery facility plans since the initial review. Every new Plan contains a new EON requirement and

[1] In one instance, when the Commissioner's Determination and Order was being appealed before an IHO, the Commissioner permitted BCBSM to file a new plan "modification" and then hold it in abeyance until after the IHO's Order was entered. Then BCBSM was permitted to implement the "modification", that contained provisions that were contrary to the IHO's Order.

each new Plan must be litigated. It is disingenuous to represent to the Courts that Appellants are obligated to continue to litigate within the never-ending provider class plan process. Whatever flows from it is instantly negated with the filing of a new plan (that can occur anytime except during the 6-months after the Commissioner begins a seldom occurring review). Furthermore, the issues raised by the Appellants are questions of law; it is the province of the Courts to say what the law is. *Marbury, supra.* Here, the interpretation of law is necessary to determine whether or not the Commissioner or BCBSM may enforce requirements that concern medical provider "need". Thus, it is essential to determine whether or not such a strained application of *1980 PA 350* is an unconstitutional usurpation of licensing authority that the Legislature has delegated only in the *Public Health Code*. In part, the reason for the Appellee's continued failure to realize that BCBSM may not impose licensure or "need" requirements may be due to a lack of understanding of the practical application of the *Public Health Code* regarding these issues. Thus, the Appellee's claim of primary jurisdiction (upon which the Circuit Court based its dismissal of Appellants' Complaint) must fail. The Court in *Durcon Co. v Detroit Edison Co., 250 Mich App 553, (2002)* the Court stated whether or not the Court should defer to primary jurisdiction depends upon: (1) whether the question at issue requires the special expertise of the agency (Appellee possesses no special expertise regarding medical provider "need"); (2) the need for uniform resolution of the issue (we are better served by the Court interpreting the law to avoid two standards for Appellants (and many others) to meet in order to enjoy their rights

in their licensure under the *Public Health Code*); and, (3) whether judicial resolution will have a adverse impact on the agency's performance (here, a great burden would be lifted, since the provider class plan review has resulted in two more revised provider class plans being filed in less than a year without resolving the issues in dispute.) This matter is clearly a question for the Court.

The provider class plan process addresses a "reimbursement arrangement" as specifically defined by the *Act*; it "means policies, practices and methods by which a health care corporation make payments to a provider to implement the provider class plan." *MCL 550 1108(1). See also 550.1107(7), definition of Provider Class Plan.* Finally, in *BCBSM v Milliken, 1 Mich 422; 1 NW2d 367 (1985), pp 43 & 44, 47(last line) – 50; 23-24 & 25-27*, the Court made it clear that BCBSM was not a state planning agency and that **no governmental function** had been delegated to BCBSM under the *Act.* In fact, had the *Act* attempted to delegate the legislative licensure power to determine medical provider "need" or any power to alter the rights in and criteria for medical licensure to BCBSM, such provisions would have been constitutionally infirm, lacking a specific delegation and lacking standards as precise as the subject matter requires or permits. *Milliken, supra, pp 51-52; 27, citing Osius v St Clair Shores, 344 Mich 693, 698; 75 NW2d 25 (1956), Dept. of Natural Resources v Seaman, 396 Mich 299, 309; 240 NW2d 206 (1976) and Argo Oil Corp v Atwood, 274 Mich 47, 53; 264 NW2d 285 (1935). And citing State Highway Comm v Vanderkloot, 392 Mich 159, 174; 220 NW2d 416 (1974)* stating that due process requirements must be satisfied for the statute to pass constitutional muster. (The

Court struck the *Act's* language creating a panel of three actuaries to determine risk factors.) The Court in *In re 1987-88 Medical Doctor Provider Class Plan 203 Mich App 707; 514 NW2d 471 (1994)* provides the limitations of the provider class plan review, stating that the Commissioner may only determine whether the plan substantially achieved the goals in *Sec. 504* of the *Act* and its objectives. The Court further stated that the IHO on Appeal may only affirm or reverse the Commissioner's determination. This process offers no remedy.

Contrary to the Appellee's assertions, an actual controversy exists now and has always existed in this matter. BCBSM, that controls a majority of the health care coverage market, has refused to recognize Blakewoods' state licensure, for participation or for reimbursement to its patients, based on BCBSM's EON determination. On October 11, 2001, Blakewoods executed the only form of participation agreement that BCBSM would permit that required Blakewoods to cease rendering any surgical procedure that is not related to ophthalmology in order to obtain and continue limited participation with BCBSM.[2] Blakewoods' licensure grants it the right to perform outpatient surgery in all surgical specialties, so Blakewoods had to withdraw staff privileges from a number of physicians who perform other types of surgeries and its owner-surgeons not specializing in ophthalmology had to stop performing surgeries in the facility. Blakewoods lost use of the equipment that it had purchased to perform all other surgeries. BCBSM now unlawfully imposes restrictions on Blakewoods' license by requiring that, in order to receive BCBSM recognition for

[2] Appellants did not raise the restricted participation agreement issue in their application for leave to appeal because they had not yet entered into or been offered such an agreement.

multi-specialty surgery, the facility must have a minimum of 3 operating rooms in use—Blakewoods' state licensure does not require this. Blakewoods has 2 rooms in use. On *p 15* of his Brief, Appellee alleges that Blakewoods received payment from BCBSM member, Ms. McLennan, when BCBSM refused payment for her surgery. Blakewoods had to write this off as a bad debt.

MCL 550.1603(4) (5) & 550.1605 provide that if the Commissioner learns from any examination or report that BCBSM has violated the law, he is required to take action and is provided a means of doing so. The Commissioner knew BCBSM was unlawfully imposing EON requirements and had a duty to prohibit this activity. *Sec. 619(3)* of the *Act* makes it clear that Appellants had standing and the Court had jurisdiction to compel the Commissioner to stop the unlawful and unauthorized actions of BCBSM. Appellants began this action in the Ingham Co. Circuit Court before the Commissioner ordered the provider class plan review. The provider class plan review offers no remedy. Appellants are not barred by either *res judicata* or collateral estoppel, since the provider class plan review may not interpret questions of law, but is narrowly limited by statute. Appellants agree that the standard of review for primary jurisdiction is *de novo*. *(Appellees' Brief, p 20.)*

Appellants' Table of Docket Entries is attached as the last page of this Brief.

Dated: August 20,2002

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2/9/01	44	Motion: Rehearing of Opinion Proof of Service: 2/9/01 Notice Date: 2/27/01 Check No. 3532 Fee: $75.00 Ans. Due: 2/23/01 Filed by Attorney: 37287 – Fausey, Linda For Party: 1 PL – AT	SDOMKE
2/29/00	25	Brief: Reply Proof of Service: 2/29/2000 OA: Timely Filed	DALLEN
1/5/00	13	Brief: Appellant Proof of Service: 1/5/00 OA: Y Timely Filed: Y Filed by Attorney: 37287 – Fausey, Linda	PJUECKSTOCK

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6/23/99	23	Motion & Brief for Reconsideration or Rehearing of Ord Granting Dfs Motn for Summary Disp; Certs 062399 Upon DFS Counsel; Filed/PLS
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1/8/99	24	Brief Supporting Pls Answer to Dfs Motn for Summary Disp; Certs 010898 Upon Df; Filed/PLS
12/21/98	19	Miscellaneous Motion Cross & Brief For Partial Summary Disp on Compl for Declaratory Judg & Inj Relief; Noti Hrg 01/13/99 @ 8:50 AM; Certs 122198 Upon Larry Brya: Filed/PLS
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